STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295055	A. BUILDING _____ B. WING _____	04/09/2010

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COLLEGE PARK REHABILITATION CENTER	2856 E. CHEYENNE AVE. NORTH LAS VEGAS, NV 89030

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification survey conducted at your facility from April 6, 2010 through April 9, 2010, in accordance with 42 CFR Chapter IV Part 483 Requirements for States and Long Term Care Facilities. The census at the time of the survey was 88. The sample size was 19, including three closed records. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their written policies and procedure for screening of employees. Four of eight (#1,#3,#5,#7) employee files reviewed lacked documentation screening and background checks were completed. Findings include:	F 226	**F 226 Development of Abuse/Neglect** *The facility will follow the policies that prohibit mistreatment, neglect, and abuse of residents as evidenced by;* What corrective action will be accomplished for those residents found to have been affected by the deficient practice? • **Employee #1,3,7 have been corrected** How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken? • **Audit by HR after every hire, and before orientation or start date of all hires to the facility.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie M Fiebo

TITLE: Administrator

(X6) DATE: 4/29/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 On 4/9/10 at 1:50 PM personnel files for employees #1,#3,#5,#7 lacked documentation employee screening and background checks were completed. On 4/9/10 at 2:15 PM, a staff member from Human Resources stated she was not able to locate documentation of employee screening and reference checks for employees #1, #3, #5 and #7. The facility's policy entitled, "What you Need to Know " Abuse Prohibition (revised 2/2008) documented "Pre employment background screening is mandated for all employee of the facility." The facility's Human Resources Policy and Procedure (revised 1/2007) documented the facility would verify and certify the accuracy of information provided by applicants and employees in a resume or application. Background investigations included an examination and verification of References (job experience, education, work performance and training).	F 226	• What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: • **All Hiring managers with hiring authority will be in serviced on hire packets and our policy regarding these** How will the facility monitor its corrective action to ensure that the deficient practice is being corrected and will not recur: ie: what programs will be put into place to monitor the continued effectiveness of the systemic change. • **Monthly Audits for three months. Quarterly audits for two quarters and every 6 months thereafter** • **Review with CQI committee following each audit** Monitored by: ***HR Director and Administrator to assure compliance*** Completion date: 5/12/2010	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure one resident	F 241	**F241 Dignity and Respect of an individual** *Facility will promote respect to the residents in a manner that maintains and or enhances each residents dignity and respect as an individual as evidenced by:* • What corrective action will be accomplished for those that have been affected by this deficient practice.	

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F 241	Continued From page 2 (#20) received privacy during the administration of eye drops. The facility staff failed to ensure staff knocked before entering occupied eight resident rooms. Findings include: 1. On 4/8/10 at 6:50 AM, a Licensed Nurse (LN) was observed administering eye drops to a Resident #20 in the "E" hallway while other residents were in the hallway and main activity room. On 4/8/10 at 2:20 PM, the LN on "E" Hallway was asked if it was appropriate to administer eye drops to a resident in the hallway. She replied "No, for privacy it should be done in their room." On 4/9/10 at 8:10 AM, Resident #20 provided no response when spoken to. Review of his medical record documented the resident was aphasic and had unclear speech. 2. On 4/8/10 at 7:00 AM, during an observation of a medication administration a LN was observed entering resident Room 16 (occupied with one resident) without knocking or announcing himself prior to entering. On 4/8/10 at 8:00 AM, a Certified Nursing Assistant (CNA) was observed entering resident Room 5 (occupied with one resident) without knocking or announcing herself prior to entering. On 4/8/10 at 8:02 AM, a CNA was observed entering resident Room 4 (occupied with two residents) without knocking or announcing herself prior to entering. On 4/8/10 at 8:05 AM, a CNA was observed	F 241	• **#20, eye drops are being given in the privacy of his room** How will you identify others who may have been affected by this deficient practice? • **Random checks of med administration completed by DON or designee, and Pharmacist to assist** • **A facility (non clinical) manager assigned to each wing to do spot checks daily on med passes to see if any are done with privacy; and on knocking on doors before entering resident rooms.** • **In-services on med passes, treatments, and knocking, and patient rights on privacy to all staff will be completed.** How will the facility monitor its corrective action to ensure that the deficient practice is being corrected and will not recur? • **At admission of each resident, within 72 hours, a team of managers will meet to orient the resident and family to the facility. At this time privacy will again be addressed by a College Park representative.**	

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F 241	Continued From page 3 entering resident Room 4 (occupied with two residents) without knocking or announcing herself prior to entering. On 4/8/10 at 12:00 PM, a LN was observed entering resident Room 26 (occupied with one resident) without knocking or announcing herself prior to entering. On 4/8/10 at 1:35 PM, a CNA verified she was taught to knock before entering a resident's room. According to the facility's Admission Handbook, #14, "Each resident has the right to privacy with regard to treatment, communications and personal care."	F 241	• **Admission paperwork will be completed and again privacy and dignity to be addressed** • **Resident council meeting will be held monthly to address privacy as it relates to treatment or med passes. Dignity and respect to privacy of personal space will be addressed at this meeting.** • **Resident rap sessions to meet weekly for two months and then monthly thereafter to address privacy.** What measures will be put into place to monitor the continued effectiveness of systemic change to assure this deficient practice does not recur? • **Random rounds with audit form by hallway assignment and documentation to be completed daily in each shift for 90 days and weekly thereafter.** • **CQI committee to address any issues that come from these audits for immediate education.** Monitored by: ***Social Service Coordinator/ Activities director Administrator to assure compliance*** Completion date: 5/12/2010	

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F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Social Services followed-up on a resident who may have needed a legal guardian to assist in making informed decisions for 1 of 19 sampled residents (Resident #8). Findings include: Resident #8 was a 48 year-old male admitted on 10/24/06 with diagnoses including depressive disorder and Down's syndrome.	F 250	**F 250 Medically related Social Service** ***The facility will provide medically related Social Services to assist each resident in attaining their highest physical, mental and psychosocial well being.*** What corrective action will be accomplished for those residents found to have been affected by the deficient practice? • **Resident # 8 Guardianship has been applied for** How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken?	

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F 250	Continued From page 4 A review of Resident #8's daily skilled nursing notes revealed the resident was alert, had short term memory loss, and was disoriented to person, place, time and situation. The annual Minimum Data Set (MDS) dated 03/11/2010 documented the resident did not have a legal guardian nor was the resident responsible for self. The resident had short term and long term memory problems. The resident was able to recall the location of own room and staff names/faces. The resident was identified as modified independent (some difficulty in new situations only) for daily decision making skills. On 04/07/10 at 1:30 PM, interview with the Social Worker revealed the resident was able to make needs known and able to make daily decisions. The resident would not be able to understand the risks and benefits related to making informed health care decisions. The Social Worker indicated the resident did have a Public Guardian when the resident was first admitted to the facility. The resident's case was then transferred to a private guardian and the resident did have a family member who was previously involved in the resident's care. At the time of the survey, the resident did not have a legal guardian to assist with making informed health care decisions.	F 250	• **All patients with questionable daily decision making skills on the MDS (B4) will be brought to IDT immediately for identification of guardianship services possibly needed** • **A whole house audit of section (B4) will be completed to assure residents paperwork is right and guardianship services are not needed.** • **Charge Nurses will identify within their scope of practice patient's ability to understand in the first 24 hours after arrival by assessment. If identified as a concern the patient will be put on the 24 hour report to be addressed immediately by Social Services for potential guardianship** What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur; • **Immediate guardianship services will be initiated after admission assessment and or paperwork signing that may be questionable.**	

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F 250	**Continuation of F 250**	F 250	• **Speech therapy/Occupational therapy will do a cognitive evaluation following any sign of confusion noted by staff, prior to guardianship to concur with staff.** • **Social Service to complete a Mini Mental assessment** • **MDS will communicate (B4) identifying cognitive issues** How will the facility monitor its corrective action to ensure that the deficient practice is being corrected and will not recur; i.e.: what programs will be put into place to monitor the continued effectiveness of the systemic change? • **Social Service to audit all new admits within 48 hours to do Mini Mental for cognitive evaluation** • **Business office to audit all new admits for paper work completion within 48 hours of admission** • **Therapy to screen any identified patients for cognitive evaluation in reference to paperwork within 48 hours, so that application for guardianship can occur** Monitored by: ***Social Service Administrator to assure compliance*** Completion date: 5/12/2010	

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	**F 281 Services provided meet professional standards** ***The facility will assure professional standards are met daily as evidenced by;***	

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F 281	Continued From page 5 Based on observation, interview and record review the facility failed to follow the standards of practice for administration of a heart medication for 1 of 9 sampled residents (Resident #1). The facility failed to follow their written policy and procedure for securing medication and the medication cart. Findings include: Resident #1 1. Resident #1 was admitted on 11/21/08 and re-admitted on 10/31/09 with diagnoses including congestive heart failure, hypertension and end stage renal disease. Resident #1 had a physician's order dated 10/31/09 for Digoxin 125 micrograms (mcg) orally per day. On 4/7/10 at 7:30 AM, during an observation of the medication pass, the nurse checked Resident #1's pulse and blood pressure with an automated wrist blood pressure and pulse machine. The resident received Digoxin 125 mcg orally from the nurse. During the observation an apical pulse was not obtained and the nurse was not observed taking a pulse for a full 60 seconds. On 4/8/10 at 8:30 AM, during an observation of the medication pass the nurse checked Resident #1's pulse and blood pressure with an automated wrist blood pressure and pulse machine. The resident then received Digoxin 125 mcg orally from the nurse. During the observation an apical pulse was not obtained and the nurse was not observed taking a pulse for a full 60 seconds.	F 281	What corrective action will be accomplished for those residents found to have been affected by the deficient practice; • **Resident #1 pulse is being monitored daily for Digoxin** • How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken; • **On admission patients meds will be reviewed to identify any orders for Digoxin** • **At every IDT all TO's will be reviewed to identify any new orders for Digoxin**	

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F 281	Continued From page 6 On 4/8/10 at 1:20 PM, a Licensed Nurse (LN) from "D" hallway was asked if she was to give a resident the medication Digoxin, how long would she take the pulse. The LN replied for a full minute, apically with a stethoscope. On 4/8/10 at 10:25 AM, the Director of Nursing (DON) was asked what her expectations were for the nurse's when giving Digoxin. The DON stated "ideally" the apical pulse should be taken. This was a standard of practice. The facility's reference book entitled, "Nursing 2010 Drug Handbook 30th Anniversary Edition, by Wolters Kluwer/Lippincott Williams & Wilkins pages 445 and 446 documented before giving the drug, take apical-radial pulse for one minute. Record and notify prescriber of significant changes..." Resident #1's Medication Administration Record for March 2010 and April 1 through April 7, 2010, lacked documentation the resident's pulse rate was recorded daily with each dose of Digoxin received. Resident #1's medical record lacked consistent documentation in the nurse's notes the pulse rate was being monitored daily for the drug Digoxin. The vital sign flow sheet lacked documentation after 1/11/10. 2. On 4/9/10 at 8:10 AM, a Licensed Nurse (LN) was observed in Room 3 talking on her cellular telephone with her back to the unlocked medication cart. A plastic medication cup containing 2 pills was observed on top of the medication cart. A resident was observed	F 281	What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur; • **Random audits of med passes with the drug Digoxin will be done to assure Apical Pulse is being taken according to standard of practice before administration of this medication** • **Medical Records audit at admission will identify the use of Digoxin and the MARS will be audited for documentation of the Apical Pulse** • **New digital vital sign machines were purchased** • **All LN in-services on standards of practice on Digoxin Administration** How will the facility monitor its corrective action to ensure that the deficient practice is being corrected and will not recur; ie: what programs will be put into place to monitor the continued effectiveness of the systemic change. • **Random audits of MARS will be monitored daily for 30 days and then weekly for 30 days and monthly thereafter to identify correct documentation of the pulse on all patients on Digoxin**	

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F 281	Continued From page 7 approaching the medication cart. On 4/9/10 at 8:15 AM, the LN was asked if medication should be left on top of the cart. She replied, "No". The LN was asked if the medication cart should be left unlocked. She replied, "No". The facility's policy and procedure on Medication Management (10/2008) documented, "The medication cart is kept in sight or locked at all times. No medications or dangerous articles, gloves, lancets are left on top of the cart."	F 281	• **Two Licensed Nurse will complete Recap monthly and review MARS of all patients on Digoxin to assure compliance** • **Licensed Nurses will be randomly observed daily for med pass and "locking" of the medication cart for patient safety.** *Charge Nurse to monitor; DON to assure compliance* Completion Date: 5/12/2010	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F 329 Unnecessary Drugs** ***All residents will be free from*** ***unnecessary drugs***	

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F 329	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure there was an appropriate clinical indication for the use of Seroquel and Risperdal for two of 19 sampled residents (Residents #3, #9). Findings include: 1. Resident #3 Resident #3 was an 84 year-old female admitted on 11/08/07 and readmitted on 01/18/09 with diagnoses including hypotension, dehydration, general muscle weakness, diabetes, leukocytosis, renal failure, depressive disorder and abnormality of gait. The transfer summary dated 01/12/09, documented the resident's diagnoses included: hypotension, leukocytosis, dehydration, acute renal insufficiency, diabetes mellitus type 1, dementia, and anemia. The transfer summary dated 01/12/09, documented the resident's discharge medications included: aspirin, Clopidogrel (Plavix), Donepezil (Aricept), Lovenox, Lisinopril, Megestrol Acetate (Megace), Memantine (Namenda), multivitamins, Simvastatin, and Hydrocodone. The Physician Progress notes dated 12/22/09, documented the resident's assessment included renal failure, congestive heart failure, general muscle weakness, diabetes, uncomplicated type II, dementia w/o (without) behavioral disturbance,	F 329	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? • **Residents #4 and #9 have been corrected** How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken? • **An audit of all residents on any psychotropic drugs will be completed to evaluate appropriate diagnosis** • **New telephone orders will be reviewed in IDT meetings to assure a diagnosis to support the medication use**	

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F 329	Continued From page 9 and abnormality of gait. The Physician Recapitulation (Recap) Orders for March 2010, documented Seroquel 25 milligram (mg) at bedtime was ordered on 04/15/09. The diagnosis for the Seroquel was depressive disorder. A review of the Medication Administration Record for February 2010 and March 2010 revealed the resident received Seroquel 25 mg every night at bedtime. The Pharmacy Review dated 02/04/10, documented "Recommend review diagnosis for Seroquel 25 mg tablet. Antipsychotics should not be used if the following are the only indications: Dementia, depressive disorder, Senile Dementia." On 04/09/10 in the afternoon, interview with the Minimum Data Set (MDS) Coordinator revealed the Seroquel was ordered due to the resident had a diagnosis of agitation and depression. There was no documented evidence to support the use of Seroquel for the resident. 2. Resident #9 Resident #9 was an 83 year old female admitted 3/10/09 and readmitted 11/14/09. The Transfer Summary dated 11/13/09 indicated diagnoses of acute renal failure (resolved), hypernatremic dehydration (resolved), urinary tract infection, history of dementia, and history of glaucoma. The Resident Admission Record indicated diagnoses of dysphasia, muscle weakness,	F 329	What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? • **Social Service to conduct a psychotropic committee to meet and evaluate weekly, all residents that are on psychotropic drugs.** • **At recap time, all psychotropic meds will be reviewed by the LN to assure that a corresponding diagnosis is there to support the medication** • **DON to assure all pharmacy audits are completed by physicians within two weeks of pharmacy visits.**	

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	295055	A. BUILDING _____ B. WING _____	04/09/2010

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F 329	Continued From page 10 persistent mental disorder NEC (Not Elsewhere Classified) (Preliminary), urinary tract infection, gait abnormality, rehabilitation procedures, glaucoma, findings on exam of urine other nonspecified, adverse effects SIRS (systemic inflammatory response system) due to sepsis, and essential hypertension. The Physician's Recap for April 2010 indicated a physician's order of Risperdal, 0.25 mg, 1 tablet BID (twice daily), for a diagnosis of persistent mental disorder, start date 11/14/09 - "Open Ended". The Recap also indicated a Standing Order of "Psychology consult as needed, start date 11/14/09 - Open Ended". The Care Plan dated 11/25/09 indicated psychosis. There was no specific diagnosis of psychosis in the chart. There was no documented evidence of a justification for the use of Risperdal. There was no documented evidence the facility attempted a gradual dose reduction and behavioral intervention. There was no documentation to support the use of Risperdal. On 4/7/10 and 4/8/10, the Director of Nursing (DON) reviewed the resident's chart and confirmed there was no documentation of a justification for the use of Risperdal and no documented diagnosis of a mental illness or psychosis. The DON further indicated there was no facility policy regarding the use of psychotropic or antipsychotic medications.	F 329	How will the facility monitor its corrective action to ensure that the deficient practice is being corrected and will not recur; i.e., what programs will be put into place to monitor the continued effectiveness of the systemic change? • **Random Audits by Pharmacist to be completed** • **Monthly CQI to review results of audits and psychotropic meetings to correct any deficiencies found** Monitored by: ***SDC/DOE and DON*** Completion date: 5/12/2010	

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F 329	Continued From page 11 On 4/7/10 and 4/8/10, two nurses were interviewed regarding Resident #9's moods and behaviors. Both nurses indicated Resident #9 had not demonstrated any signs of psychosis or behaviors of mania, agitation, or anxiety.	F 329		
F 334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's	F 334	F 334 Influenza and Pneumococcal *The facility will assure that each resident and or their representative receives education before administering the influenza immunization* What corrective action will be accomplished for those residents found to have been affected by the deficient practice; • **No residents were identified** How will you identify other residents having the potential to be affected by the same deficient practice. and what corrective action will be taken; • **An audit of all residents in house will be completed to assure education was provided and consent was given in writing**	

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F 334	Continued From page 12 legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to ensure the influenza vaccine policies utilized by the facility were consistent. Findings include:	F 334	What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? • **All LN will be re-educated to which policy is in place for the Influenza immunization** • **Medical records to audit weekly for 30 days and monthly thereafter for each resident record.** How will the facility monitor its corrective action to ensure that the deficient practice is being corrected and will not recur; i.e., what programs will be put into place to monitor the continued effectiveness of the systemic change? • **Admission packets will be checked for accuracy prior to admission of each new resident to assure proper forms and policies are used.**	

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F 334	Continued From page 13 The facility policy titled "Infection Control Policies and Procedures Standing Order for Immunization" dated 03/2006, documented the following "...Procedures: 1. Patient/Residents are counseled on the benefits and adverse effects of each vaccine, and a consent/refusal form is offered to the patient/resident prior to administration of vaccine...3. If the patient/resident consents to the immunizing agent included in these orders: A. Obtain signature from patient/resident..." The facility policy titled "Infection Control Policies and Procedures Influenza Vaccine Administration and Disease Control" dated 03/2006 and revised 05/2008, documented the following "...C. Consent signatures are not required, since the administration of influenza vaccine is a federal mandate for all patients/residents living in skilled nursing facilities, unless contraindicated..." The facility had two policies with different directions regarding the need to obtain patient/resident signature prior to administering the vaccine.	F 334	• **Review monthly at LN meetings results of all audits and CQI findings regarding correct policy implementation** • **CQI committee to review audits correct as needed** Monitored by: ***Medical Records DON to assure compliance*** Completion Date: 5/12/2010	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	**F 441 Infection Control** ***The facility will maintain an infection control program designed to provide a safe, sanitary, and to prevent the spread of infections.***	

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F 441	Continued From page 14 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all staff followed policy and accepted professional standards for infection control (isolation) and precautionary measures (handwashing). Findings include: 1. On 4/8/10 in the late morning, a dietary aide came in through a door which opened to the	F 441	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? • **No residents cited**	

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F 441	Continued From page 15 outside and went to the handwashing sink. After washing her hands, the dietary aide turned the faucet off with her wet hand and then took a paper towel from the dispenser just above the sink. On 4/8/10 in the late morning, the main dietary aide came off the line, removed her gloves and went to the handwashing sink. After washing her hands, she turned the faucet off with her wet hand and then took a paper towel from the dispenser just above the sink. On 4/8/10 at 12:00 PM, another dietary aide was at the handwashing sink washing her hands. The aide turned the faucet off with her wet hand and then took a paper towel from the dispenser just above the sink. On 4/8/10 in the afternoon, a registered nurse (RN) placed a gown into the trash can on the way out of a room designated as requiring contact isolation precautions. The RN looked in the medication administration record and then walked down the hall. No hand hygiene was observed. 2. The facility's policy (dated 3/06) titled Infection Control Policies and Procedures revealed " ...1. Hand hygiene/hand washing is done after: ... H. After removal of medical/surgical or utility gloves... I. Contact with a patient's/resident's intact skin (e.g. taking a pulse or blood pressure, performing physical examinations, lifting the patient/resident in bed)... 3. B...Use towel to turn off the faucet ..." Another page within the same policy showed an elbow being used to turn off the water. The instructions read, "Turn water faucet off with a	F 441	How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken? • **Nursing staff will be re-educated in proper hand washing technique with a return demonstration** • **Dietary staff will be re-educated to proper hand washing techniques with direct regard to food handling** What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? • **A manager is assigned to every hallway throughout the day to make random rounds for hand washing procedures. Identified staff will be re-educated to the policy of proper hand washing at that time.**	

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F 441	Continued From page 16 sanitary, single-service towel, or your elbow." A second policy (revised 10/28/09) titled Surveillance, Prevention and Control of Infections indicated " ...Wash hands: 2. C. Before putting on gloves, when changing into a fresh pair of gloves, and immediately after removing gloves... A. 6) Turn water off using a dry paper towel or a blower type dryer activated with the elbow." 3. During the initial tour on 4/6/10 at 8:30 AM, a Licensed Nurse (LN) verbalized the resident in Room 30 had the diagnosis of clostridium difficile. The LN was unsure if the resident was on isolation precautions. After consulting with a staff member, the LN stated the resident was on isolation precautions. No viewable sign was posted on the resident's door. A staff member entered the room and came out with the isolation sign, placing it on the door. The LN stated the sign should always be posted on the door. The facility's policy and procedure on Infection Control (3/2006) documented for contact, droplet and airborne isolation as sign stating "Please stop at the nurse's station before entering" was sufficient. 4. On 4/7/10 at 7:35 AM, during a medication pass a LN washed her hands with soap and water, then turned the faucet off with her wet hands and obtained a paper towel to dry her hands. On 4/7/10 at 7:50 AM, during a medication pass a LN washed her hands with soap and water, turned the faucet off with her wet hands and obtained a paper towel to dry her hands.	F 441	• **At time of hire, hand washing will be educated to all depts. And return demonstration will occur prior to starting their job** • **Isolation rooms will be identified appropriately and reviewed daily for compliance** • **LN will be in serviced on all isolation techniques for any isolation room** • **A daily list of all identified isolated residents will be kept at the Nurses station and all staff educated daily to any identified resident, When off precautions patient's name will be removed from daily list, sign will be removed and care plan updated.** How will the facility monitor its corrective action to ensure that the deficient practice is being corrected and will not recur; ie: what programs will be put into place to monitor the continued effectiveness of the systemic change. • **Hand washing return demonstration will be completed for every employee every month for three months and quarterly thereafter.**	

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F 441	Continued From page 17 On 4/7/10 at 9:15 AM, during a medication pass a LN washed her hands with soap and water, turned the faucet off with her wet hands and obtained a paper towel to dry her hands. On 4/8/10 at 8:33 AM, during the medication pass a LN washed her hands with soap and water, turned the faucet off with her wet hands and obtained a paper towel to dry her hands.	F 441	• **CQI to review any targeted areas of concern after return demonstration in hand washing is complete.** • **Charge Nurse and hallway monitors to check daily for appropriate signage to assure identified isolation residents have precaution in place** Monitored by: *Director of Education and Don to assure compliance* Completion date: 5/12/2010	